Comments on the Health Policy Commission' Patient-Centered Medical Homes Standards for Certification Pathway

Vinfen is pleased to respond to the Health Policy Commission's Request for Comments regarding Patient-Centered Medical Homes Standards for Certification Pathway.

BASIS FOR COMMENTS

Established in 1977, Vinfen is a private, nonprofit human services organization and the largest provider of contract services to the Massachusetts Department of Mental. Each year, Vinfen provides a comprehensive array of services to about 7,000 adults and transition age youth with psychiatric, developmental and behavioral disabilities, with a staff of about 2500, in over 300 programs in Eastern Massachusetts and Connecticut. These services include Community Based Flexible Supports [CBFS] teams as well as PACT teams [Programs for Assertive Community Treatment] funded by the Massachusetts Department of Mental Health for persons with severe major mental illness (SMI). For persons with severe intellectual and developmental disabilities (IDD) and acquired brain injuries (ABI) a similar range of services are provided.

Over the past decade Vinfen has engaged in several projects designed to assess medical risks, and the scope and care of chronic disease in the populations we serve. We have also engaged in several internal initiative and three federally supported research projects with Dr. Stephen Bartels' team at Dartmouth, all designed to improve health and wellness in the SMI population. At the current time, we are completing year two of a Center for Medicare and Medicaid Innovation grant providing funding to evaluate a Community Behavioral Health Home Model for individuals with SMI. In that project, nurse practitioners and health outreach workers are imbedded into CBFS outreach teams of Vinfen and three other providers, and two technologies are added- a telemetry monitoring and coaching system and a Dartmouth-developed emerging evidence based training program - Integrated Illness Management and Recovery, which are used to help monitor and teach individuals to manage their health issues. Utilization and financial data to date have been encouraging in showing reductions in Emergency Room and Hospitalizations. The project suggests that this model could be sustainable through the Massachusetts One Care Plan funding, as well as through the Massachusetts State Plan Amendment for Behavioral Health Homes.

Our comments that follow are based on the experiences noted above, and our familiarity with behavioral health home models operated by colleagues in other states.

STANDARDS FOR POPULATION MANAGEMENT

Vinfen agrees with the suggested definition of a patient centered medical home (PCMH) as care that is accessible, coordinated, person and family-centered, comprehensive, continuous, compassionate, culturally-competent, and in which the primary care physician shares responsibility for the patient's health and well-being with other participants involved in providing care.

In general, we agree with the proposed standards and certification highway for PCMH.

Our concern is with the standard regarding population health management, and the following criteria:

- Under the BASIC Pathway- the empaneling of all patients to primary care provider/care teams.
- Under the Advanced Pathway: the system for at risk, high risk, complex care patients.
- Under the Optimal Pathway:
  - Care management pathways appropriate to patient risk status
  - Identify and plan care around social/environmental risk factors

Our general concern is that the PCMH should be structured to refer patients which fall into certain sub-populations into Behavioral Health Homes, and not enroll them in the PCMH system.

While for many patients a PCMH model that is population based, physician led, and focused on providing traditional medical care is appropriate, there is a cohort of individual with Serious Mental Illness (SMI) and Intellectual and Developmental Disabilities (IDD) for whom this model is not the best solution. These individuals are complex.

Adults with Serious Mental Illness experience significant health challenges, with a higher percentage of chronic medical conditions, including cardio-metabolic disorders, diabetes, chronic obstructive pulmonary disorders (COPD), and others, and early mortality with a life expectancy 25 years lower than the general population.[1]

For individuals with SMI and IDD served by Vinfen and other existing community providers, a lack of care is marked by major disparities in access. Our experience has been that many individuals with SMI or IDD do not see their PCP as frequently as other sub-populations of the larger health care system. In the SMI population served by DMH, it is not unusual for a PCP to see an individual once annually, whereas Psychiatrists may see individuals monthly, and other healthcare professionals such as Vinfen nursing or clinical staff see individuals

multiple times a week, if not daily. Other specialists in chronic diseases, such as pulmonologists for COPD or internal medicine for diabetes may also see clients much more frequently. However, the individual's principle engagement with the entire health care system, and a substantial part of care coordination is often through the community services provider. Colleagues in other community based behavioral health organizations in Massachusetts report the same patterns of service.

Our experience is also supported in the literature on health disparities for the SMI population. We understand that the Commonwealth is considering data from the Massachusetts healthcare system, the literature on SMI and IDD and chronic medical conditions, and the comments of providers and advocates in developing Behavioral Health Home models. We also encourage the Commission to consider standards for PCHM systems which encourage the appropriate referral to and empaneling into Behavioral Health Homes of patients with SMI and IDD and chronic health conditions .

CONCLUSION

We propose that patients who meet CMS' definition for Health Home eligibility should be excluded from the PCMH pool, and referred for care coordination to Health Homes. These criteria include patients who:

- Have 2 or more chronic conditions
- Have one chronic condition and are at risk for a second
- Have one serious and persistent mental health condition

The PCMH certification criteria developed by the Health Policy commission should involve integration and payment incentives that take advantage of existing, well functioning and effective community resources for care coordination for that cohort of the highest users of services who suffer from a major psychiatric disorder [such as schizophrenia] and/or developmental disorder [such as mental retardation or severe autism] and who--if they have additional medical comorbidities as are very commonly seen—are at the highest risk of premature death due to disparities in access to care as well as all other defining goals of PCMH. CBFS and PACT services should serve as a model for care coordination and any new system should recognize their already existing, unique role and not attempt to reinvent a successful and effective system.